

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14419

Item 8 Film G304

172/62 1Wk

14387

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtwn		c. LENGTH OF STAY IN It 1 day	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) St. Mary's Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Ridge	
3. NAME OF DECEASED (Type or print) Spencer Marshall Barnes		d. STREET ADDRESS 1	
4. DATE OF DEATH Month December Day 1 Year 19 61		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1892 April 6, 1892
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR Months 69 Days 69 Hours 69 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Augustus Barnes		14. MOTHER'S MAIDEN NAME Julia M. Dean	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Edith M. Barnes		Address Ridge, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Digitalis Intoxication DUE TO (b) Dehydration DUE TO (c) Hemiplegia from Cerebral Thrombosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 20g. (City or town) (County) (State)		INTERVAL BETWEEN ONSET AND DEATH 2 days 2 wks. mo.	
21. I certify that (I) (the hospital) attended the deceased from May 12, 1961 to May 12, 1961 , that (I) (we) last saw the deceased alive on May 12, 1961 , and that death occurred at 11:30 A.M. from the causes and on the date stated above.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
22a. SIGNATURE James P. Jure M.D.		22b. DATE SIGNED 12/2/61	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/4/61	
23c. NAME OF CEMETERY OR CREMATORY St. Michael's		23d. LOCATION (City, town or county) (State) Ridge, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley		25a. REC'D BY REGISTRAR OFF 6 '61	
ADDRESS Leonardtwn, Maryland		25b. REGISTRAR'S SIGNATURE Arthur S. Knaus	



1941

St. Mary's

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TO BE FILLED BY THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. The law also requires that the death certificate be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14420

CERTIFICATE OF DEATH

14388

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY St. Mary's	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Oakley Rural		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS X Rural Oakley	
3. NAME OF DECEASED (Type or print) First Mary Middle Robey Last Butler Beverley		4. DATE OF DEATH Month December Day 23 Year 1961	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 18, 1890
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months 12 Days 05 Hours 00 Min. 00	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Butler		14. MOTHER'S MAIDEN NAME Elizabeth Collins	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war and dates of service) no		16. SOCIAL SECURITY NO. 578-30-0509	
17. INFORMANT Mrs Emily Clarke		Address 455 Baimbridge Brooklyn, N.Y.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) (c) Coronary infarction		INTERVAL BETWEEN ONSET AND DEATH immediate	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug 17, 1961 to Dec 23, 1961 , that (I) (we) last saw the deceased alive on Dec 17, 1961 , and that death occurred at 6 A.M. from the causes and on the date stated above.			
22a. SIGNATURE William D. Boyd		22b. DATE SIGNED 12/23/61	
22c. PHYSICIAN'S NAME (Type) William D. Boyd M.D.		22d. ADDRESS Leonardtowh, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/27/61	
23c. NAME OF CEMETERY OR CREMATORY Sacred Heart		23d. LOCATION (City, town or county) (State) Bushwood, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley		24. ADDRESS Leonardtowh, Maryland	
25a. REC'D BY REGISTRAR DEC 28 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

1932

St. Mary's

Calvary Chapel

St. Mary's

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14421

14389

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY St. Mary's							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown				c. LENGTH OF STAY IN 1b 7 days							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Mary's Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Hannah Middle Emma Last Bowles				4. DATE OF DEATH Month 12 Day 5 Year 1961							
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 27, 1884					
9. AGE (In years last birthday) 77 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME French Marcellis Abell				14. MOTHER'S MAIDEN NAME Hannah Gertrude Abell							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No				16. SOCIAL SECURITY NO. None							
17. INFORMANT George H. Bowles				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (b) Generalized arteriosclerosis (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes				INTERVAL BETWEEN ONSET AND DEATH 1 week 10 yrs			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from July , 19 60 to Dec 5 , 19 61 , that (I) (we) last saw the deceased alive on Dec 5 , 19 61 , and that death occurred at 11:30 PM from the causes and on the date stated above.											
22a. SIGNATURE P. J. Bean				22b. DATE SIGNED 12/6/61							
22c. PHYSICIAN'S NAME (Type) P. J. Bean M. D.				22d. ADDRESS Great Mills, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 9, 1961		23c. NAME OF CEMETERY OR CREMATORY St. John's Cemetery		23d. LOCATION (City, town or county) (State) Hollywood, Maryland					
24. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley				25a. REC'D BY REGISTRAR DEC 12 '61							
ADDRESS Leonardtown, Maryland				25b. REGISTRAR'S SIGNATURE L. F. Frawley							

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1931

St. Mary's Hospital

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St. Mary's Hospital

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14422

14390

1. PLACE OF DEATH a. COUNTY St. Marys MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Marys			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown				c. LENGTH OF STAY IN 1b X Loveville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Marys Hospital				d. STREET ADDRESS Rural		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM CHARLES BOWLES, Sr.				4. DATE OF DEATH Month Day Year December 18 1961			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 30, 1861		9. AGE (In years last birthday) 100 yrs.	IF UNDER 1 YEAR Months 5 Days 18	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm Owner		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John I. Bowles (dec.)				14. MOTHER'S MAIDEN NAME Mary M. Graves (dec.)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -----		17. INFORMANT Address Mignonette C. Wathen - Loveville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) 491X DUE TO (c) 							INTERVAL BETWEEN ONSET AND DEATH 72 hrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Cardiovascular dis							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from JUNE 1956 to DEC 17 1961 , that (1) (we) last saw the deceased alive on DEC 17 1961 , and that death occurred at 3P M. from the causes and on the date stated above.							
22a. SIGNATURE J. Roy Guyther		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12/18/61			
22c. PHYSICIAN'S NAME (Type) J. Roy Guyther, MD		22d. ADDRESS Mechanicsville, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/21/61		23c. NAME OF CEMETERY OR CREMATORY St. Joseph Cem.		23d. LOCATION (City, town, or county) (State) Morganza, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE P.B. Robinson - Leonardtown, Md.				25a. REC'D BY REGISTRAR DATE DEC 26 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

My dear Sir,

I have the honor to acknowledge the receipt of your letter of the 10th inst. in relation to the matter of the

and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.

I am, Sir, very respectfully,
Your obedient servant,
J. H. [Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

HEALTH DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
14423											
14391											
1. PLACE OF DEATH a. COUNTY St. Mary's b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Leonardtwn c. LENGTH OF STAY IN 1b Life d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) St. Mary's Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural California d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Richard Alexander Clarke				4. DATE OF DEATH Month December Day 21 Year 19 61							
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 18, 1908		9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR Months 53 Days 53 Hours 53 Min. 53	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman				10b. KIND OF BUSINESS OR INDUSTRY Maryland				11. BIRTHPLACE (County & State, or foreign country) U.S.A.			
13. FATHER'S NAME Alexander Clark				14. MOTHER'S MAIDEN NAME Henrietta Jones							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. 219-16-2308				17. INFORMANT Margaret H. Clarke California, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 204.0 DUE TO Septicemia - due to thrombocytopenia Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. DUE TO Lymphoid leukemia - acute DUE TO 9 mos INTERVAL BETWEEN ONSET AND DEATH 48 hrs											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 12/23/61											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year 19 Hour p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) Mechanicsville, Maryland											
21. I certify that (I) (this hospital) attended the deceased from Dec 21, 1961 to Dec 21, 1961 , that (I) (we) last saw the deceased alive on Dec 21, 1961 , and that death occurred at 12/22/61 from the causes and on the date stated above.											
22a. SIGNATURE Robert S. Sher				22b. DATE 12/22/61							
22c. PHYSICIAN'S NAME (Type) Robert S. Sher				22d. ADDRESS Mechanicsville, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 12/ 23/61				23c. NAME OF CEMETERY OR CREMATORY St. John's Cemetery			
								23d. LOCATION (City, town or county) (State) Hollywood, Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley				ADDRESS Leonardtwn, Maryland				25a. REC'D BY REGISTRAR JAN 2 '62			
								25b. REGISTRAR'S SIGNATURE Arthur S. Frank			

M

14483

CONFIDENTIAL

1. Name: [illegible]
2. Address: [illegible]
3. Date: [illegible]

1. Name: [illegible]

2. Address: [illegible]
3. Date: [illegible]
4. Name: [illegible]

1. Name: [illegible]

2. Address: [illegible]

[Handwritten signature]

1. Name: [illegible]

2. Address: [illegible]

3. Date: [illegible]

CERTIFICATE OF DEATH

Reg. Dist. No.

14392

14424

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown		c. LENGTH OF STAY IN 1b 4 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Mary's Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Harry Middle Last Combs		4. DATE OF DEATH Month December Day 26 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 15, 1876
9. AGE (In years lost birthday) 85 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Combs		14. MOTHER'S MAIDEN NAME Susie H. Stone	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
INFORMANT Address Dr. Charles Greenwell Leonardtown, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO (b) Chronic myocarditis DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 26, 1961 to Dec 26, 1961 , that I last saw the deceased alive on Dec 26, 1961 , and that death occurred at 2 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Charles Greenwell		ADDRESS (Street, city or town, state) Leonardtown Md	
PHYSICIAN'S NAME (Type) Charles Greenwell M.D.		LOCATION (City, town, or county) (State) Leonardtown, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/28/61	22c. NAME OF CEMETERY OR CREMATORY Our Lady's Chapel	
22d. LOCATION (City, town, or county) (State) Medley's Neck, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley		ADDRESS Leonardtown, Maryland	
24a. REC'D BY REGISTRAR DATE 2 '62		24b. REGISTRAR'S SIGNATURE William S. Thomas	

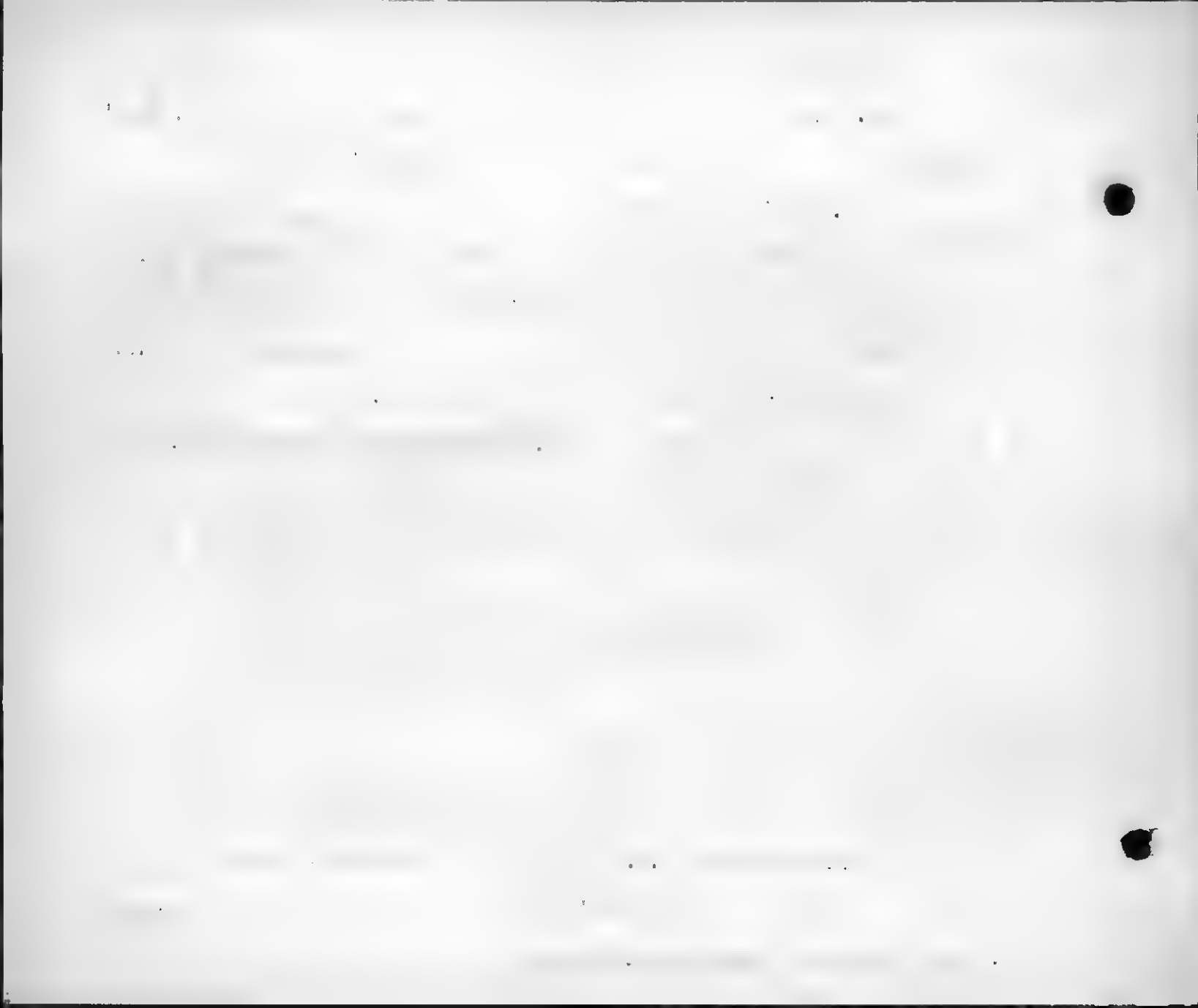
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be re-issued by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death



VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

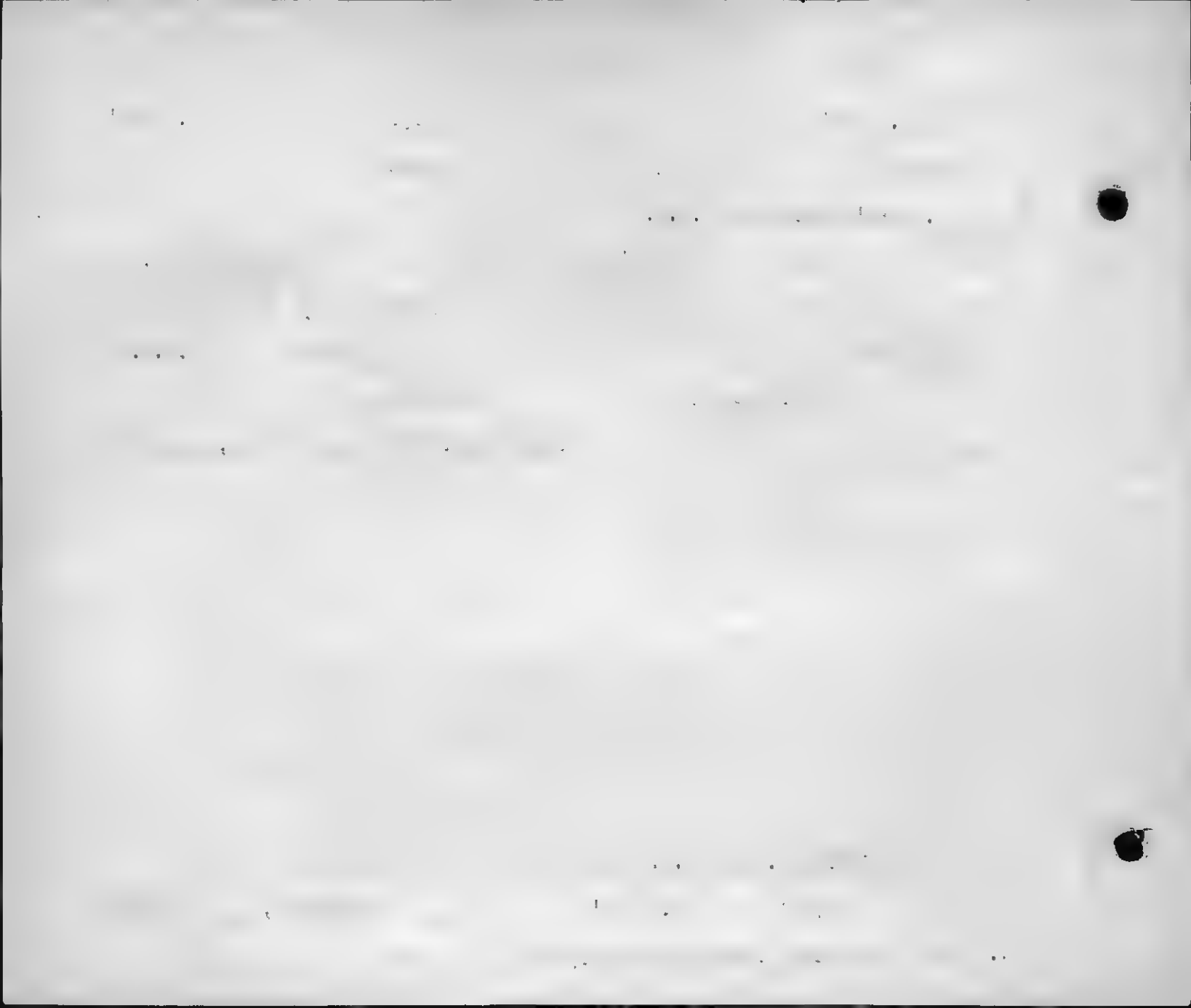
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14425

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14393

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE		b. COUNTY	
St. Mary's		Maryland		St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Leonardtown		Life		Leonardtown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
St. Mary's Hospital D.O.A.					
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH		5. SEX	
John Louis Curtis		December 23, 1961		Male	
6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
Colored		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		? ? 1908	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Day Laborer				Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
George Curtis		Jane Cutch		U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
no				Theresa Curtis	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 812X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		Fractured Skull		Leonardtown, Maryland	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Hit by auto		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
22c. TIME OF INJURY Hour 7:10 p.m. Month, Day, Year 12-23-61		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route #5	
22f. (City or town) Leonardtown		20f. (County) St. Mary's		20g. (State) MD	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE William D. Boyd M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 12-23-61	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
William D. Boyd M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
Address (Street, city, town, or county)		22b. DATE THEREOF 12/27/61		22c. NAME OF CEMETERY OR CREMATORY St. John's	
Burial		22d. LOCATION (City, town, or country) Hollywood,		22e. (State) Maryland	
23. FUNERAL DIRECTOR W. Clarke Mattingley Leonardtown, Maryland		24a. REC'D BY REGISTRAR DEC 28 '61		24b. REGISTRAR'S SIGNATURE C. J. S. Thomas	

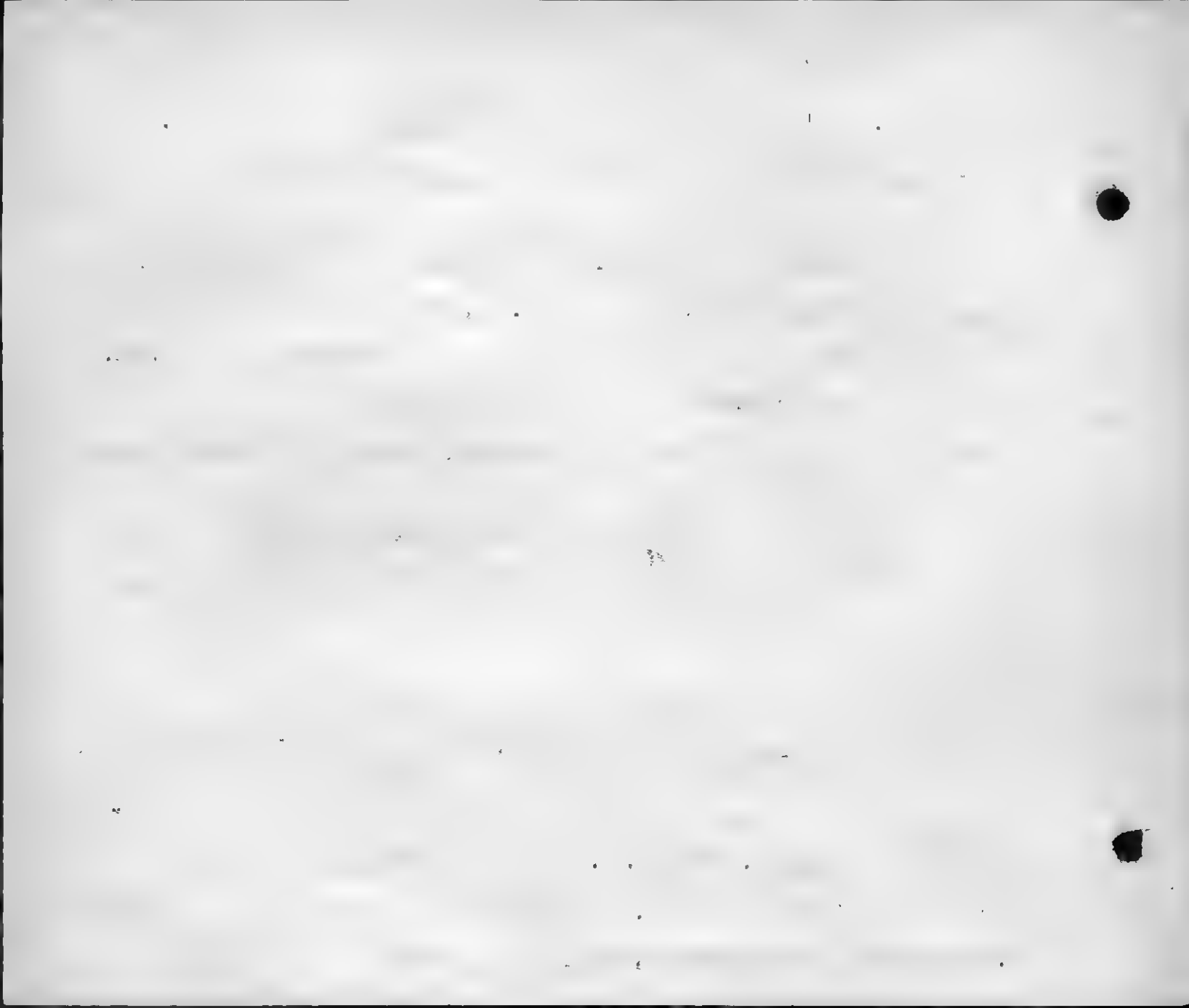


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 3 & 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
14428									
14394									
1. PLACE OF DEATH a. COUNTY St. Mary's b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural Valley Lee c. LENGTH OF STAY IN b Life d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY St. Mary's c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural Valley Lee d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Mary Valeria Cutchember First Middle Last					4. DATE OF DEATH December 10, 1961 Month Day Year				
5. SEX Female 6. COLOR OR RACE Colored 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH Feb. 14, 1875 9. AGE (In years last birthday) 86 yrs. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife 10b. KIND OF BUSINESS OR INDUSTRY Home 11. BIRTHPLACE (County & State, or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A.					13. FATHER'S NAME Robert Brown 14. MOTHER'S MAIDEN NAME Ellen ?				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no 16. SOCIAL SECURITY NO. none 17. INFORMANT Mrs Lindsay Briscoe Tall Timbers, Maryland Address					18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular Fibrillation 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Myocardial Infarction (c), stating the underlying cause last Coronary Insufficiency PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH min min hrs				
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				
21. I certify that (I) (the hospital) attended the deceased from Jan. 1961 to 12/10, 1961 , that (I) last saw the deceased alive on 12/10, 1961 , and that death occurred at 10 P.M. from the causes and on the date stated above.									
22a. SIGNATURE James P. Jarboe 22c. PHYSICIAN'S NAME (Type) James P. Jarboe M.D.					22b. ADDRESS Great Mills, Maryland 22d. ADDRESS 22e. DATE SIGNED 12/19/61				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 12/15/61 23c. NAME OF CEMETERY OR CREMATORY St. George Cemetery 23d. LOCATION (City, town or county) (State) Valley Lee, Maryland					24. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley ADDRESS Leonardtown, Maryland 25a. REC'D BY REGISTRAR DEC 18 '61 25b. REGISTRAR'S SIGNATURE J. H. H.				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

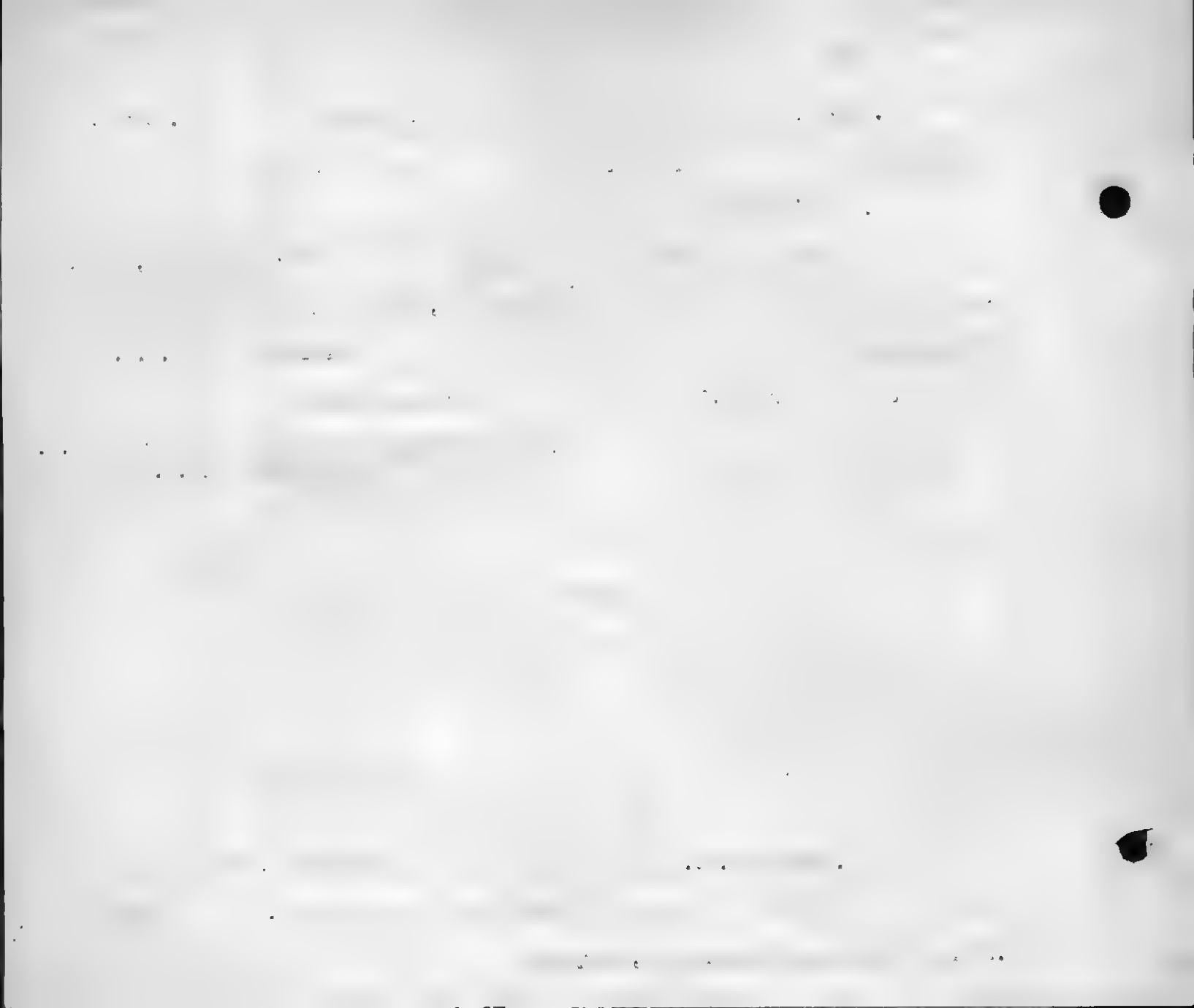
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14427

14395

1. PLACE OF DEATH a. COUNTY St. Mary's b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Leonardtown c. LENGTH OF STAY IN IT 15 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) St. Mary's Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Maryland b. COUNTY St. Mary's c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural Chaptico d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James Middle Burgess Last Davis		4. DATE OF DEATH Month December Day 10 Year 1961	
5. SEX Male 6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH August 20, 1910 9. AGE (In years last birthday) 51 yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Edward Davis		14. MOTHER'S MAIDEN NAME Elizabeth Burgess	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 16. SOCIAL SECURITY NO. 17. INFORMANT Address Mrs Anne Dorothea Davis 2508 32nd Street S.E. Washington 20, D.C.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepato-Renal failure 5'18X DUE TO Conditions, if any, which gave rise to immediate cause (b) Paralytic ileus (c) Gangrene of the small bowel PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12/10 1961 , 12:30p to 12:30p , 1961 , that (I) (we) last saw the deceased alive on 12/10 1961 , and that death occurred at 12:30p 1961 , from the causes and on the date stated above.			
22a. SIGNATURE A. Samadi M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) A. Samadi M. D.		22d. ADDRESS Leonardtown, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/12/61	
23c. NAME OF CEMETERY OR CREMATORY Christ Episcopal Cemetery		23d. LOCATION (City, town or county) (State) Chaptico, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley		24. ADDRESS Leonardtown, Maryland	
25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE J. S. Evans	
DATE DEC 15 '61			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14428 Items 13 & 14 Film G305 1/19/62 1WK

Reg. Dist. No. 14428

1. PLACE OF DEATH a. COUNTY St. Mary's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Lexington Park c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Lexington Park d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Louis Middle Fletcher Last Fletcher		4. DATE OF DEATH Month December Day 28 Year 1961	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> Unknown DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH ? ? ? 1900
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months 61 Days 61 Hours 61 Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Handy man		10b. KIND OF BUSINESS OR INDUSTRY One of the Southern States	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Infarction DUE TO 42 c. Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH 6 hrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour 19 a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE William D. Boyd		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) William D. Boyd M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 1/4/62	
22c. NAME OF CEMETERY OR CREMATORY W. of Md. Med. School		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Mattingly Funeral Home		24a. REC'D BY REGISTRAR AN 5 '62	
Address Lenoard, Md.		24b. REGISTRAR'S SIGNATURE James L. Kline	

TO DEPUTY MEDICAL EXAMINER: This certificate should be completed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar for burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers on pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

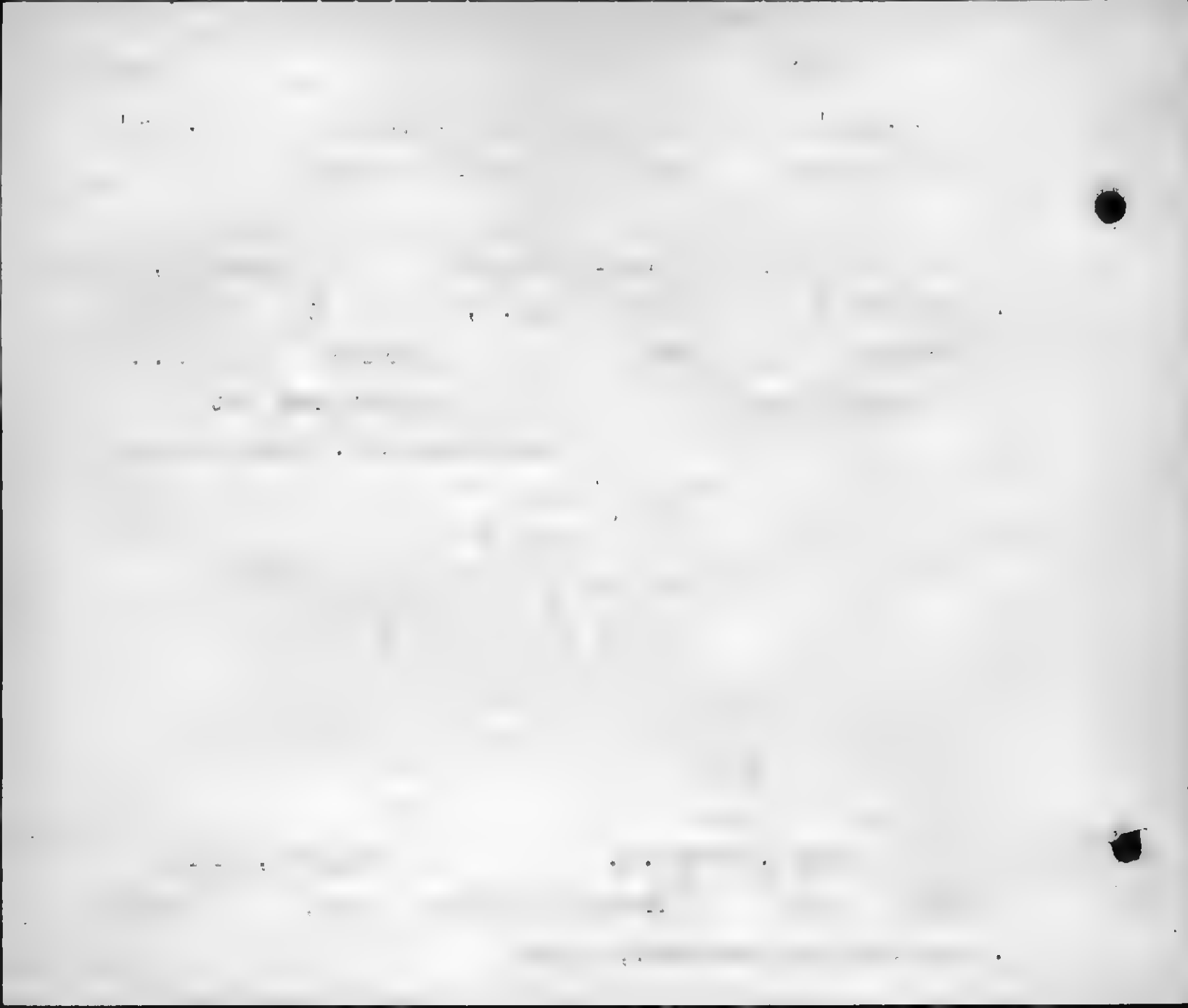
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14429

CERTIFICATE OF DEATH

14396

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Scotland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Scotland	
c. LENGTH OF STAY IN IL Life		d. STREET ADDRESS Rural Scotland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			
3. NAME OF DECEASED (Type or print) First Amy Middle Mabel Last Greenwell		4. DATE OF DEATH Month December Day 16 Year 1961	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 6, 1874	
9. AGE (In years IF UNDER 1 YEAR last birthday) 87 yrs.		10. AGE (In years IF UNDER 1 YEAR last birthday) 87 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (Country & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Yeatman		14. MOTHER'S MAIDEN NAME Ann Maria Lamb	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Albert Greenwell Jr.		Address Ridge, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 154X DUE TO Chronic Bronchopneumonia Conditions, if any, which gave rise to immediate cause (b) Cachexia (c) Adenocarcinoma of rectum cause last. ASCVD			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan. 1960 to 12/16, 1961 , that (I) (we) last saw the deceased alive on 12/16, 1961 , and that death occurred at 12/16, 1961 , from the causes and on the date stated above.			
22a. SIGNATURE James P. Jarboe M.D.		22b. DATE SIGNED 12/17/61	
22c. PHYSICIAN'S NAME (Type) James P. Jarboe M. D.		22d. ADDRESS Great Mills, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/19/61	
23c. NAME OF CEMETERY OR CREMATORY Friendship Methodist		23d. LOCATION (City, town or county) (State) Ridge, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley		24. ADDRESS Leonardtwn, Maryland	
25a. REC'D BY REGISTRAR DEC 20 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kiana	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7,61

MARYLAND STATE DEPARTMENT OF HEALTH

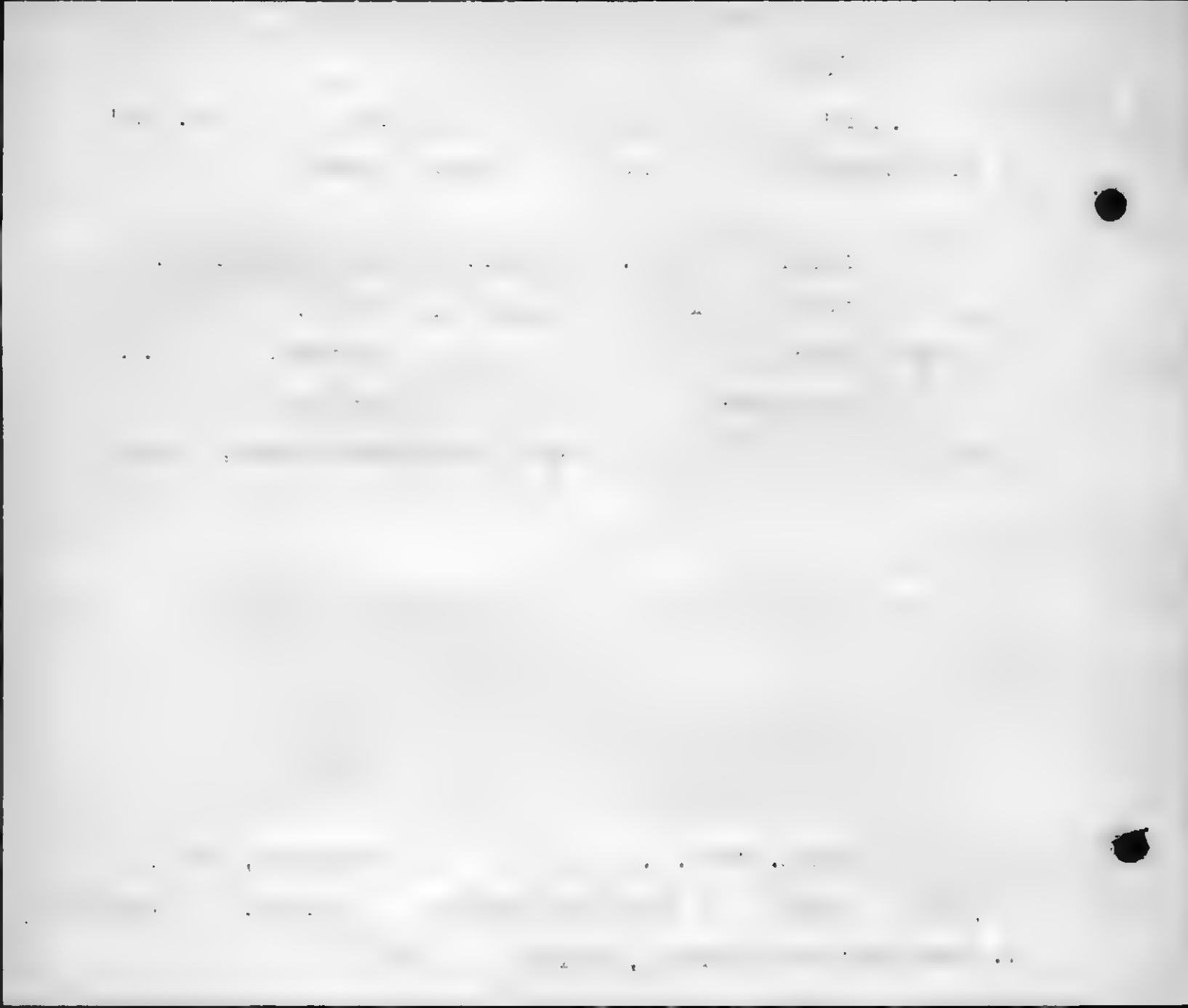
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14430

CERTIFICATE OF DEATH

14397

1. PLACE OF DEATH a. COUNTY St. Mary's b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural Bushwood c. LENGTH OF STAY IN IL Life d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Rural Bushwood		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY St. Mary's c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural Bushwood d. STREET ADDRESS Rural Bushwood	
3. NAME OF (Type or print) First William Middle T. Last Herbert		4. DATE OF DEATH Month December Day 16 Year 19 61	
5. SEX Male		6. COLOR OR RACE Colored	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 1, 1878	
9. AGE (in years last birthday) 83 yrs.		10. IF UNDER 1 YEAR Months 83 Days 83 Hours 83 Min. 83	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House man & Farmer		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Herbert		14. MOTHER'S MAIDEN NAME Harriet Butler	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. Walter Harry Herbert	
17. INFORMANT Walter Harry Herbert		18. ADDRESS Oakley, Maryland	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Central hemorrhage Conditions, if any, which gave rise to immediate cause (b) Generalized arteriosclerosis (a), stating the underlying cause last. (c) 10 yrs.		INTERVAL BETWEEN ONSET AND DEATH Immediate	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1953 , 19 to Dec , 1961 , that (I) (we) last saw the deceased alive on 16 Dec 19 61 , and that death occurred at 10AM , from the causes and on the date stated above.			
22a. SIGNATURE Joseph E. Gill		22b. DATE SIGNED 12/18/61	
22c. PHYSICIAN'S NAME (Type) Joseph E. Gill M. D.		22d. ADDRESS Leonardtown, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/20/61	
23c. NAME OF CEMETERY OR CREMATORY Sacred Heart Cemetery		23d. LOCATION (City, town or county) (State) Bushwood, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley		25a. REC'D BY REGISTRAR DEC 20 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Thomas			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 3 and 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

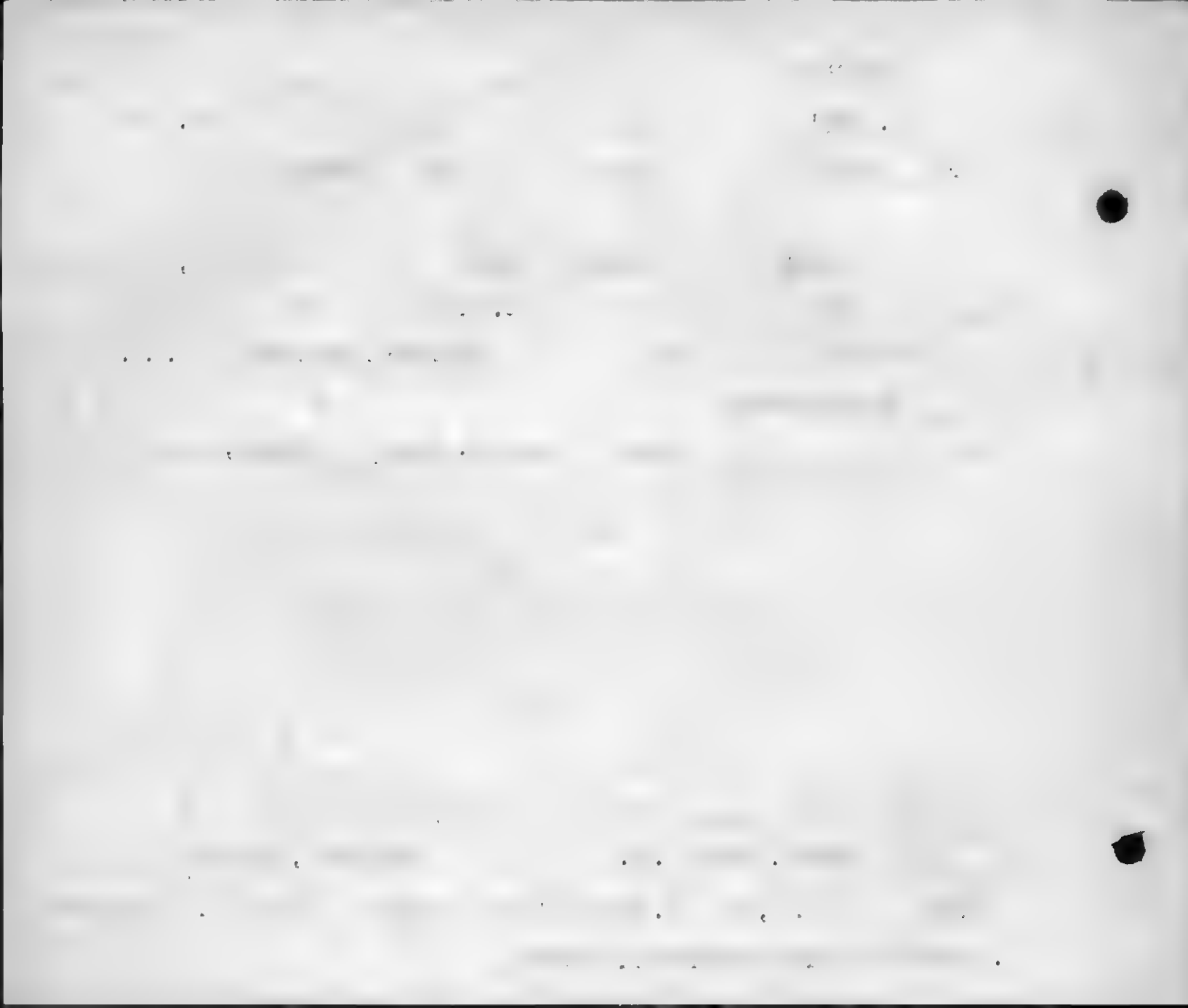
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14431

Item 14 Film G-502 12/12/61 144398

1. PLACE OF DEATH a. COUNTY St. Mary's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Drayden c. LENGTH OF STAY IN b 8 years d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rural Drayden		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY St. Mary's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Drayden d. STREET ADDRESS 1		a. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Jessie Middle McKenny Last Magee		4. DATE OF DEATH Month December Day 3 Year 19 61			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH Dec. 5, 1878		9. AGE (In years, last birthday) 82 yrs.		IF UNDER 1 YEAR Months Days Hours Mins. 1 wk. 4 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME George McKenny		14. MOTHER'S MAIDEN NAME Elizabeth Jane Young	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Robert A. Magee Address Drayden, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular Fibrillation DUE TO (b) Intractable Congestive Heart Failure DUE TO (c) ASCVD PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus		INTERVAL BETWEEN ONSET AND DEATH minutes		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. City or town (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12/1/1961 to 12/3/1961 , that (I) last saw the deceased alive on 12/3/1961 , and that death occurred at 4:25 a.m. from the causes and on the date stated above					
22a. SIGNATURE James P. Jarboe M.D.		22b. DATE SIGNED DEC 6 '61		22c. PHYSICIAN'S NAME (Type)	
22d. ADDRESS Great Mills, Maryland		22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 5, 1961		23c. NAME OF CEMETERY OR CREMATORY St. George Episcopal Cemetery	
23d. LOCATION (City, town or county) Valley Lee, Maryland		23e. REGISTRAR'S SIGNATURE Arthur L. Kline		23f. REGISTRAR'S SIGNATURE	
24. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley		24a. ADDRESS Leonardtwn, Maryland		24b. REC'D BY REGISTRAR DEC 6 '61	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14432 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **14399**

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural California c. LENGTH OF STAY IN 1b 13 years d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural California d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Agnes Middle Cordelia Last Otterback				4. DATE OF DEATH Month December Day 13 Year 19 61											
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 22, 1881		9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Civil Service				10b. KIND OF BUSINESS OR INDUSTRY U.S. Government				11. BIRTHPLACE (State or foreign country) Fairfax County, Virginia				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Benjamin L. Otterback						14. MOTHER'S MAIDEN NAME Sarah C. Davis									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. none		17. INFORMANT Address Mrs Jean Wilkerson California, Maryland									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO acute Cordian failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerosis in heart 7 decades DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												INTERVAL BETWEEN ONSET AND DEATH 2 years			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.														20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. p. m.				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .															
ACTUAL SIGNATURE <i>William D. Boyd</i> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>												DATE SIGNED			
EXAMINER'S NAME (Type) William D. Boyd M.D.												ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 12/16/61		22c. NAME OF CEMETERY OR CREMATORY Congressional Cemetery				22d. LOCATION (City, town, or county) (State) 1801 E St. S.E. Washington, D.C.					
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown Maryland						24a. REC'D BY REGISTRAR DEC 19 '61		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>							

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar to burial, cremation, or removal.

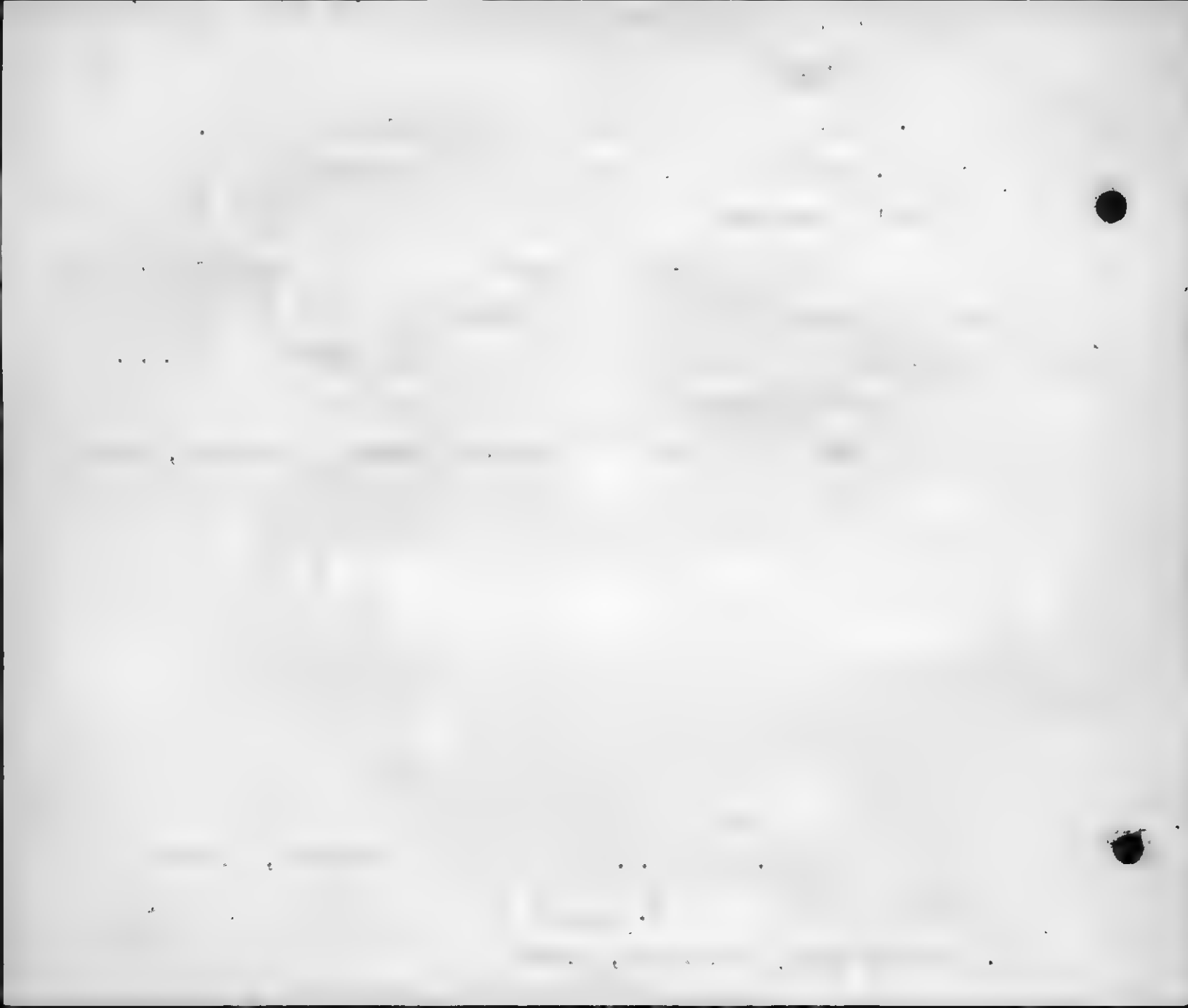


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be signed by the attending physician and completed and in by the funeral director. After this certificate has been signed by the attending physician and completed, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7-61

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
14433											
14100											
1. PLACE OF DEATH a. COUNTY St. Mary's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural St. George Island c. LENGTH OF STAY IN 1b 11 months d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Poe's nursing home				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY St. Mary's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Leonardtown d. STREET ADDRESS 1							
3. NAME OF DECEASED (Type or print) Theodore Herbert Russell				4. DATE OF DEATH December 31, 1961				9. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 21, 1888		9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming				10b. KIND OF BUSINESS OR INDUSTRY Maryland				11. BIRTHPLACE (County & State, or foreign country) U.S.A.			
13. FATHER'S NAME Patrick Russell				14. MOTHER'S MAIDEN NAME Julia Bedow							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. none				17. INFORMANT Agnes Violet Russell Leonardtown, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) 422 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Respiratory Arrest Cerebral Thrombosis ASCDVD				INTERVAL BETWEEN ONSET AND DEATH min days hrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: 22a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 22b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 22c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 22d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 22e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 22f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from May 1961 to Dec. 31, 1961 , that (I) (we) last saw the deceased alive on Dec. 31, 1961 , and that death occurred at 7:00 P.M. from the causes and on the date stated above.											
22a. SIGNATURE James F. Jarboe M.D.				22b. DATE SIGNED 1/4/62				22c. PHYSICIAN'S NAME (Type) James F. Jarboe M.D.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 1/3/62				23c. NAME OF CEMETERY OR CREMATORY St. Aloysius			
24. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley				24b. ADDRESS Leonardtown, Maryland				25a. REC'D BY REGISTRAR JAN 8 '62			
25b. REGISTRAR'S SIGNATURE Arthur S. Haines				25c. DATE JAN 8 '62							



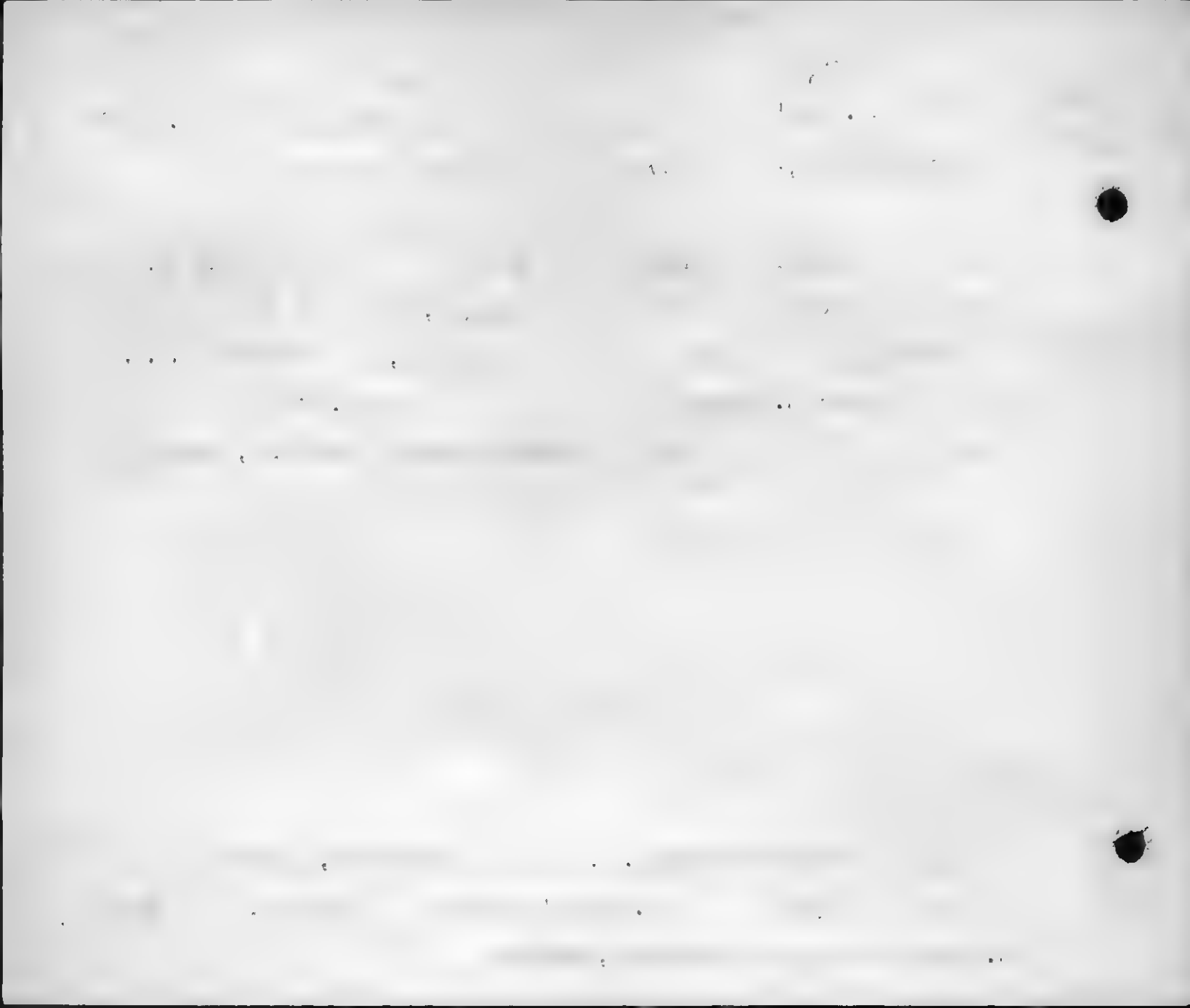
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be signed by the attending physician and completed in by the funeral director. The law also requires that the death certificate be signed by the attending physician and completed in by the funeral director. The law also requires that the death certificate be signed by the attending physician and completed in by the funeral director.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
CERTIFICATE OF DEATH										
14434										
14401										
1. PLACE OF DEATH a. COUNTY St. Mary's b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural Loveville, c. LENGTH OF STAY IN 1b Life d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural Loveville d. STREET ADDRESS					
3. NAME OF DECEASED (Type or print) Walter Morgan Russell					4. DATE OF DEATH Month December Day 6 Year 1961					
5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH January 6, 1888 9. AGE (In years last birthday) 73 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming 10b. KIND OF BUSINESS OR INDUSTRY Farm					11. BIRTHPLACE (County & State, or foreign country) Loveville, Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Robert W. Russell					14. MOTHER'S MAIDEN NAME Ellen M. Hill					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give year or dates of service)					16. SOCIAL SECURITY NO none 17. INFORMANT Bernard Russell Address Loveville, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary thrombosis DUE TO Hypertension Conditions, if any, which gave rise to immediate cause (b) Hypertension DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 420.1										INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>										
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)										
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19 6										
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>										
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)										
20f. (City or town) (County) (State)										
21. I certify that (I) (this hospital) attended the deceased from Dec 6, 1961 , to Dec 6, 1961 , that (I) (we) last saw the deceased alive on Dec 6, 1961 , and that death occurred at 6 A.M. from the causes and on the date stated above.										
22a. SIGNATURE Charles Greenwell M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										
22b. DATE SIGNED 12/7/61										
22c. PHYSICIAN'S NAME (Type) Charles Greenwell M. D.										
22d. ADDRESS Leonardtwn, Maryland										
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial										
23b. DATE THEREOF 12/9/61										
23c. NAME OF CEMETERY OR CREMATORY St. Joseph's Cemetery										
23d. LOCATION (City, town or county) (State) Morganza, Maryland										
24. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley ADDRESS Leonardtwn, Maryland										
25a. REC'D BY REGISTRAR DEC 12 1961										
25b. REGISTRAR'S SIGNATURE										



Wm. L. Kane

VR AIS (4)
15M 7.61



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
14436
14403
MIDDLE STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY St. Mary's MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE Maryland b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Patuxent River		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lexington Park, Maryland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Station Hospital, NAS, Patuxent River MD.		d. STREET ADDRESS Box 131, Three Notch Road	
3. NAME OF DECEASED (Type or print) First Middle Last Frances Josephine SKELLY		4. DATE OF DEATH Month Day Year December 25 19 61	
5 SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-21-1887
9. AGE (In years last birthday) 74 7/8 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
10b. KIND OF BUSINESS OR INDUSTRY None		11 BIRTHPLACE (State or foreign country) Ireland	
12 CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Patrick CLEARY	
14. MOTHER'S MAIDEN NAME Mary TYRELL		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO.		17. INFORMANT Address Box 131, Three Notch Rd., Lexington Park, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cessation of heart 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hemorrhage, cerebral DUE TO (c) Arteriosclerosis, vessel unknown			INTERVAL BETWEEN ONSET AND DEATH None 37 minutes 37 minutes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from 25 DEC 1961 to 25 DEC 1961, that (I) (we) last saw the deceased alive on DOA 1961, and that death occurred at 3:35 P. M. from the causes and on the date stated above.			
22a. SIGNATURE D.E. Mulhatten M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) D.E. MULHATTEN, LT MC USN		22d. ADDRESS Station Hospital, USNAS, Patuxent River, MD.	
23a. BURIAL, CREMATION REMOVAL (Specify) Burial	23b. DATE THEREOF 12/29/61	23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem.	23d. LOCATION (City, town, or county) (State) New York, N.Y.
24 FUNERAL DIRECTOR'S SIGNATURE P.B. Robinson - Leonardtown, Md.		25a. REC'D BY REGISTRAR DEC 28 '61	25b. REGISTRAR'S SIGNATURE



may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14437

14404

1. PLACE OF DEATH a. COUNTY St. Marys MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY St. Marys			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Park Hall				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Park Hall			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rural				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARY Middle ESTELLE Last SMITH				4. DATE OF DEATH Month December Day 28 Year 19 61			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 22, 1892	
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR Months 69 Days 0 Hours 0 Min. 0		11. IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper				10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Stephen Smith				14. MOTHER'S MAIDEN NAME Mary Briscoe			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. -----		17. INFORMANT Lucretia E. Smith - Leonardtown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 443X IMMEDIATE CAUSE (a) Respiratory Arrest DUE TO (b) Cerebral Hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) HAS CVD							INTERVAL BETWEEN ONSET AND DEATH min. min. yes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec. 1, 1961 to Dec. 28, 1961 , that (I) (we) last saw the deceased alive on 12/28/61 , and that death occurred at 12/28/61 M, from the causes and on the date stated above.							
22a. SIGNATURE James Patrick Jarboe				22b. DATE 12/28/61		22c. PHYSICIAN'S NAME (Type) J. Patrick Jarboe, MD	
22d. ADDRESS Great Mills, Maryland				22e. DATE 12/28/61			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/30/61		23c. NAME OF CEMETERY OR CREMATORY St. Joseph Cem.		23d. LOCATION (City, town, or county) (State) Morganza, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE P.B. Robinson - Leonardtown, Md.				25a. REC'D BY REGISTRAR DATE JAN 3 '62		25b. REGISTRAR'S SIGNATURE Charles L. Hanna	

(M)

X

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14438

14405

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Mechanicsville		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS Rural Mechanicsville	
3. NAME OF DECEASED (Type or print) First Middle Last Rachel Jackson Wade		4. DATE OF DEATH Month Day Year December 18, 1961	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 19, 1892
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Home	9. AGE (In years last birthday) 69 yrs. IF UNDER 1 YEAR: Months Days Hours Min.
11. BIRTHPLACE (Country & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Warren Hawkins		14. MOTHER'S MAIDEN NAME Sarah ??	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Benjamin P. Wade		Address KK Mechanicsville, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Central Thrombosis 443X DUE TO Conditions, if any, which gave rise to immediate cause (b) Hypertensive C.V. disease (a), stating the underlying cause last. DUE TO (c) Carcinoma, cervix -			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from....., 19..... to....., 19....., that (I) (we) last saw the deceased alive on....., 19....., and that death occurred at.....M, from the causes and on the date stated above.	
22a. SIGNATURE J. Roy Guyther		22b. DATE SIGNED 12/19/61	
22c. PHYSICIAN'S NAME (Type) J. Roy Guyther M.D.		22d. ADDRESS Mechanicsville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/22/61	
23c. NAME OF CEMETERY OR CREMATORY Ebenezer Cemetery		23d. LOCATION (City, town or county) (State) New Market, St. Mary's Md.	
24. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley		25a. REC'D BY REGISTRAR DEC 26 '61	
ADDRESS Leonardtown, Maryland		25b. REGISTRAR'S SIGNATURE Arthur S. Huns	

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W. Clarke: Assistant Secretary